

Engaging citizens in the public policy process



Perhaps the biggest challenge to the human services field is the lack of public engagement in shaping a comprehensive human services system.

Nearly all of us routinely provide “human services” to the people we love - the children we raise, the parents and other relatives we care for, and the friends and neighbors we help. Most of us also contribute to local human services programs such as food banks, holiday gift programs for children, and United Way. Yet very few people understand how private efforts and public programs fit together, and how changes in one sector affect the other.

When citizens are actively involved in making human services policy, it is nearly always because they are advocating for a single program or service - not because they are concerned about the integrity of the whole system.

It is as if, instead of lobbying for public schools, teachers and parents lobbied in separate, competitive groups for funding for English classes, math classes, or science classes. If this were the case, instead of designing public schools to provide a well-rounded education, schools would feature whichever academic discipline had the strongest advocacy group and the best lobbyists.

No one would consider this a good way to make education policy. But this is the way we make human services policy.

Given the ever-tighter resource constraints in public sector human services, this way of making policy will become more problematic over time.

What’s needed is a sustained civic conversation about what we believe to be the necessary level of services, who should receive them, and how we can ensure that private and public efforts complement and strengthen each other.

Making decisions about eligibility

Sometimes the most important decisions we make are the ones we discuss the least. This is certainly true of the way we decide who is eligible for government-paid human services.

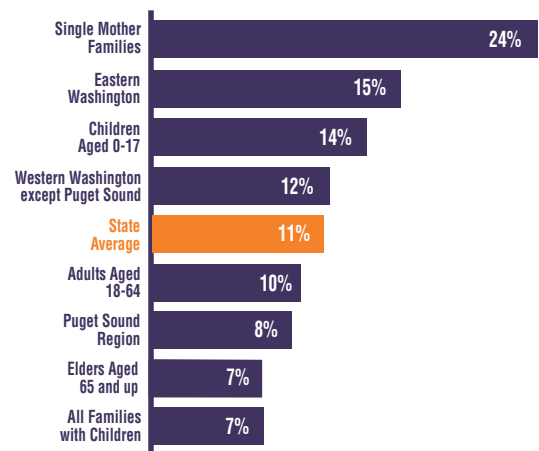
Eligibility for these services is often shrouded in complex rules that vary widely from one program to another. Most programs have eligibility rules based on income and are provided only for the poor. But how poor is poor enough? When should people participate, through co-payments, in financing the services they receive? At what income level should people go it alone? Are there services that should be provided without regard to income?

The answers to these questions are tangled up in factors that don't always reflect real human needs or our state's values. Programs that receive federal funding are more likely to be regarded as a bargain to the state, and the availability of federal funds - and the federal rules that go with them - have a big influence on who is eligible for what.

Fluctuations in the state budget also play a major role. When times are good, eligibility often expands. When the economy is in recession, budgets are cut, and eligibility contracts - in spite of the fact that during recessions more people are in need.

Percent of Washington State Families and Residents Living at or below the Federal Poverty Level

Except those in military or living in institutions



Source: Census 2000, Summary File 3. Data drawn from the Washington State Census Data Presentation, Office of Financial Management, May 7, 2002, available on the Internet at <http://www.ofm.wa.gov/census2000/index.htm>

For instance, child care subsidies were, for several years, provided to families with incomes up to 225 percent of the federal poverty level; in 2001 they were limited to families up to 200 percent of the federal poverty level, thus eliminating help for about 1,300 families. Federal health insurance for children (the Medicaid Children's Health Insurance Program) has also fluctuated, based on the ages of children, parents' income, and changes in federal funding.

Eligibility for services can also be compromised by waiting lists. For some services, such as drug and alcohol treatment, even those who are eligible often have to wait to get help.

These issues of eligibility and availability of services have a profound impact, but we generally deal with them in little bites - one program at a time, one budget at a time - rather than thinking about the larger picture of what people need, what we can afford to provide, and what our priorities and values are.

How poor is poor enough to qualify for government help?

The answer to that question varies from one program to another – and the answer is determined by a complex mix of federal regulations and state policy and budget choices.

Income Limits for DSHS Economic and Medical Services						
Family Size and Upper Income Eligibility Limit						
Type of Service for	Type of Client	1 person	2 people	3 people	4 people	(This income limit is called ...)
State grants & limited health coverage	for adults not earning due to disabilities	\$339	\$428			GAU Payment Standard
Limited health coverage	for medically needy persons	\$571	\$592	\$667	\$742	Medically Needy income level
Federal SSI grant & health care coverage	for frail elders or disabled persons not needing institutional care	\$571	\$837			SSI grant standard (about 80% of the FPL)
Grants and health coverage	for needy families with children under 18	\$698	\$880	\$1,092	\$1,284	TANF Maximum Earned Income level
Health coverage	for children of undocumented aliens	\$739	\$995	\$1,252	\$1,509	100% Federal Poverty Level
Food stamps	for ablebodied adults & their children	\$961	\$1,294	\$1,628	\$1,962	130% Federal Poverty Level
Food stamps	for elders and adults with disabilities	\$1,219	\$1,642	\$2,066	\$2,480	165% Federal Poverty Level
Health coverage	for pregnant women	\$1,366	\$1,841	\$2,316	\$2,791	185% Federal Poverty Level
Health coverage	for children	\$1,477	\$1,990	\$2,504	\$3,017	200% Federal Poverty Level
Health coverage	for workers with disabilities	\$1,625	\$2,189	\$2,754	\$3,319	220% Federal Poverty Level
Long-term care & health care coverage	for disabled persons needing institutional care	\$1,635	\$2,453			300% of the SSI Federal Benefit Rate
Child care	for needy families with children under 12	\$1,663	\$2,239	\$2,817	\$3,395	225% of Federal Poverty Level
Health coverage	for children (SCHIP program)	\$1,846	\$2,488	\$3,130	\$3,771	250% of Federal Poverty Level

Source: EAZ Manual on Eligibility, May 2002

Building a support system for low-wage working people and the industries that employ them

A low-wage service sector and low-wage industries are facts of life in the twenty-first century economy. Food processing, farm work, fast food, custodial services, telemarketing, and retail sales are all staffed by people who make low wages and have few, if any, benefits.

The human services system is also a center of low-wage service work - in child care, home care for people with disabilities and the elderly, the staffing of many of DSHS's nonprofit partner agencies, and in the front-line staff of nursing homes and other medical facilities.

Unionization may eventually win improvements in wages and benefits for some of these workers, but it is not likely to alter the economic architecture of these industries, which rely on relatively low wages to remain in business.

Child care is a good example. Some people say that child care workers should be paid as well as college professors, since they have such an enormous influence on children's early learning and personality development. But if child care workers were paid that well, most parents would be priced out of the child care market.

The question is how we define the social contract with the people who do our society's lowest-paid (and often most difficult) jobs. Should they be able to go to a doctor when they get sick? Should their children be able to get braces on their teeth if they need them? Should they live in substandard housing? Should they have access to job training and education? Should their children get extra help if they need it to succeed in school?

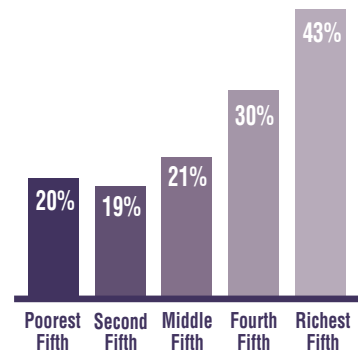
These questions ought to be at the center of today's civic conversation about combating poverty and making good on the quintessential American promise that if you work hard, you can get ahead.

Our American ideal of opportunity is that every entry level job ought to be the first rung on a career ladder, not a treadmill that keeps the poor stuck in place. But to keep this promise of upward mobility, people need access to education and training in the classroom and in the workplace.



Between the late 1970s and late 1990s the incomes of the poorest fifth increased by 20 percent, while the incomes of the richest fifth increased by 43 percent

Percent change in average income from the late 1970s to the late 1990s



Source: Pulling Apart: A State-by-State Analysis of Income Trends published by the Economic Policy Institute and the Center on Budget and Policy Priorities. Available on the Internet at: <http://www.cbpp.org/1-18-00sfp.htm>. Report uses pooled data from the three most recent years of the Census Bureau's Current Population Survey and compares it to similarly pooled data from earlier decades.

We have made important strides by offering subsidized child care to low-wage working people, and by making health insurance available to more people than most other states. Our community college system is struggling to expand targeted job training programs for low-wage workers.

Still, this system of supports is precarious and inadequate. In spite of lower poverty rates during our recent and long-running period of economic expansion, the gap between rich and poor has grown wider. Today's economy depends on a growing low-wage underclass dependent on government programs for health care, child care, and other social services.

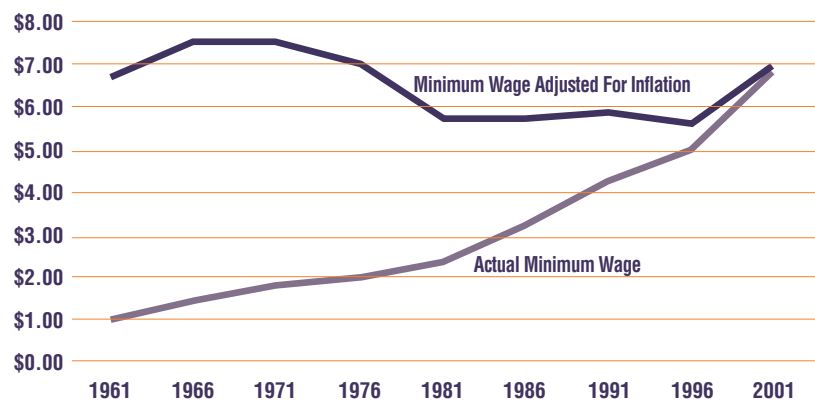
Poverty, family disorganization, and low academic achievement are closely associated. People who are poor are more likely to experience crises such as eviction and homelessness, loss of jobs because of illness or the breakdown of a car, and inability to protect children from the influence of delinquent or drug-abusing peers. The absence of affordable housing and public transit multiplies these problems.

Moreover, the low wages and scarce benefits of the service sector - combined with the aging of the population - are likely to create a critical shortage of home care workers to look after baby boomers when they become elderly and in need.

These issues need to be part of a sustained civic conversation about how we want to define the American dream - and the American reality - of the twenty-first century.

Washington state minimum wage

1961 - 2001



Source: U.S. Department of Labor Bureau of Labor Statistics Data, <http://www.bls.gov>

Reflecting and responding to Washington's diversity

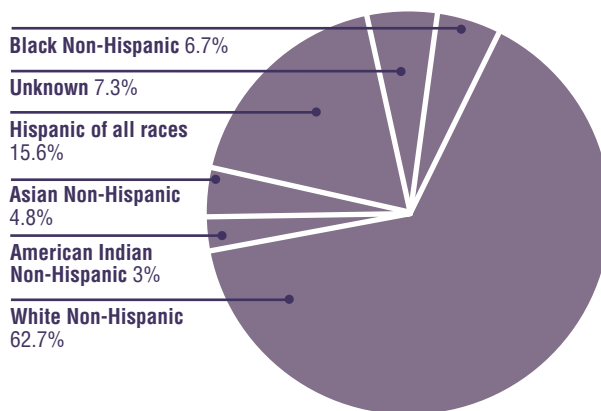
A disproportionate share of low-wage workers are people of color and immigrants. If we fail to address the needs of low-wage workers, we also fail to address the historical racial inequities that have compromised the American values of equality and opportunity.

A similar dynamic is at play in the funding, quality, and delivery of human services. The human services system serves low-income people, and a disproportionate share of low-income people are racial and cultural minorities. Thus, what happens to the system has a disproportionate impact on people of color and their communities. Cuts in programs hurt these communities more; improvements in quality and access to services benefit these communities more.

The human services system helps people overcome past inequalities and helps our society create the level playing field that is so vital to our ideal of social justice. This benefits all of us by promoting economic progress, educational success, and community and national unity.

Ethnicity and Race of DSHS Clients

Fiscal Year 2000



Source: DSHS Client Services Data Base, Research and Data Analysis, FY2000

Languages spoken by DSHS clients

Language	No. of Households
English	416,434
Spanish	42,936
Russian	9,169
Vietnamese	6,555
Korean	3,022
Chinese	2,680
Cambodian (Khmer)	1,972
Somali	947
Laotian	738
Tagalog	738
Serbo-Croatian	704
Arabic	541
Ukrainian	478
Punjabi	413
Farsi	319
American Sign Language	279
Tigrigna	245
Amharic	231
Samoan	167
Romanian	165
Ilacano	161
Hmong	147
Large Print English	141
Other Language	116
Oromo	97
Hindi	83
Japanese	75
Thai	68
Polish	66
Indonesian	62
Albanian	58
Persian	55
Un	52
French	50
Portuguese	39
Urdu	35
Bulgarian	34
Braille	26
Hungarian	25
Burmese	23
Armenian	22
Tongan	17
Mien	16
Turkish	16
Greek	15
Bengali	14
German	13
Gujarati	13
Hebrew	12
Sudanese	12
Dari	9
French Creole	9
Italian	9
Puyallup	8
Cebuano	7
Ilongo	7
Norwegian	6
Trukese	6
Vissayan	6
Chamorro	5
Danish	5
Re	5
Czech	4
Finnish	4
Haitian-Creole	4
Pashto	4
Swahili	4
Tibetan	4
Tamil	3
Malayalam	2
Marathi	2
Chiu Chow	1
Dutch	1
Ibo	1
Kmhmu	1
Macedonian	1
Shona	1

Source: TANF and Medicaid Head of Household Languages from CARD Data Warehouse for December 2001 through February 2002, as of March 2002

Responding to soaring health care costs



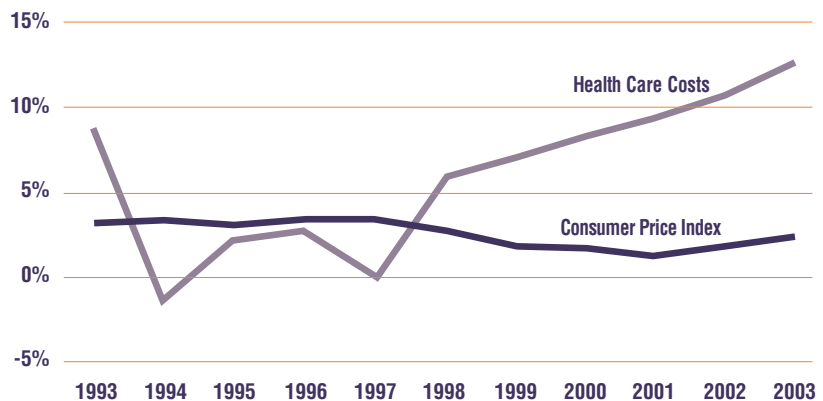
Health care costs are out of control again. After a few years of squeezing savings out of the system through managed care and other cost containment measures, we are once again facing double-digit increases in health care costs, and these increases threaten every other expenditure in the state's budget.

There is not much chance that our nation will suddenly turn a corner and adopt a system of universal health insurance. Nor is it likely that drug costs will spontaneously stabilize, or that consumers will reduce their demands on the health care system.

The problem, then, is how to manage the unmanageable: rising costs and expectations, declining employer-paid benefits, and growing demands on government to pay for services for the low-income uninsured.

Washington has done better than most states at providing health insurance to those whose employers don't offer health benefits. Our state's Basic Health Plan provides state-subsidized health insurance to low-wage workers who contribute based on their ability to pay. Still, there are people in our state who go without health care until they are so ill that they end up in emergency rooms.

Health Care Inflation 1993-2003



There are also growing problems of access. Many doctors are limiting or eliminating Medicaid patients from their practices because Medicaid pays less than private insurance. In rural areas, hospitals struggle to stay in business, and in some areas of the state, it's hard to find a doctor even for people who have insurance.

All these factors combine to put our public investments in health care for the working poor, for people with disabilities, for foster children, and for low-income seniors at risk. We will simply not be able to sustain current levels of health services in the context of today's health system and state budget.

Consumer and client groups oppose cuts in benefits, the institution of co-payments, or measures that would restrict access to high-cost drugs. Doctors and hospitals oppose cuts to payment rates that are already far below what private insurers pay.

Yet there has been little discussion of what our priorities are, and what we might be willing to give up in order to be able to afford basic health services - especially preventive health care - for all.

The crisis in our health care system is real.

University of Washington Medical Center

Service: Nonprofit healthcare for Washington residents

Medicaid clients served: 4,433 admissions out of 16,407 total; 67,037 outpatient visits out of 329,695 total.

Total Medicaid claims: \$97,825,603

Uncompensated charity care: \$6,959,772

Number of employees: 4,813

**Medicaid is a lifeline
for our state's most
vulnerable people.**



Lamontay Williams began life with many strikes against him. His mother took narcotics while she was pregnant and got no prenatal care or medical assistance until an hour before his birth. He sustained brain damage during birth. Now he is in the care of Dawn English, a veteran nurse and foster mother for fragile children. And he is in the pediatric palliative care program at Seattle's Children's Hospital. The program provides a team approach to make the best possible decisions for the 5-year-old.

Read the complete story posted on the Internet at: Facing the Future Profiles, located at <http://www.wa.gov/dshs/FacingtheFuture/NewsProfiles>

Prevention and early treatment



Kathy Plonka photo reprinted with permission of *The Spokesman-Review*, Spokane

When one house is on fire and ten need smoke alarms, fire departments turn on their sirens and rush to the house in flames. When time permits, they work on persuading the other ten households to install smoke alarms.

A similar dynamic is at work in the human services system: responding to emergencies comes first, and prevention is secondary. The problem is that responding to emergencies often exhausts the time and resources of the system, leaving too little for prevention.

Yet as surely as smoke alarms prevent catastrophic fires, preventive health care, family counseling, parent education, family planning and economic services can prevent catastrophic meltdowns in people's lives.

For example, if a teenager begins to show signs of mental illness, prompt diagnosis and early treatment can dramatically alter the course of the disease. The teen can learn to manage the disease before it becomes so out of control that it leads to drug addiction, alienation from school and family, or homelessness. Unfortunately, however, our public mental health system is not funded to identify and intervene in the early stages of mental illness; its focus is on the treatment of those whose illnesses are most acute and advanced.

Early intervention and remediation of a whole range of problems - diabetes, child neglect, alcohol addiction, and joblessness, for instance - can save a great deal of money and prevent a great deal of human suffering.

In some instances, we are making progress on prevention. WorkFirst provides for emergency assistance with expenses such as car repairs when doing so will keep someone working and prevent the need for longer-term assistance. More assertive family planning programs have reduced unintended pregnancies among people receiving assistance.

But on the whole, our human services system responds to flames, not smoke. For many services, eligibility is restricted to those whose illnesses, economic circumstances, or family problems constitute a crisis - a crisis that was probably preventable.

When and where we do invest in prevention, we see specific, measurable gains. Investments in family planning, for instance, have succeeded in reducing teen pregnancy rates and unintended pregnancies among those on WorkFirst.

Finding the means - and the will - to invest in more prevention and early treatment would be a major piece of progress for our human services system and our society.

Integrating people with disabilities into the community

In the mid-twentieth century, institutional care was the norm for people with developmental disabilities and the mentally ill, and many people with physical disabilities were consigned to life in nursing homes. The civil rights movement of the 1960s inspired people with disabilities and their advocates to press for fuller inclusion in community life, more choices about how and where to live, and a new focus on the person rather than the disability. The civil rights movement of people with disabilities has made important strides in shifting the focus of services for people with disabilities away from custodial, institutional care, and towards greater autonomy, self-directed care, and freedom of choice.

Over the years, there has been a steady decline in the number of people with disabilities who live in institutions, and an increase in the number who live in their own homes or apartments, in adult family homes or group homes.

But at this moment in history, we are still betwixt and between. Old attitudes and institutions are still with us. Court decisions, federal laws, and most advocates push the system toward de-institutionalization. But there is a counter-movement of defenders of institutions for people with developmental disabilities that includes families of people who have lived in those institutions for 40 years or more, and for whom the institution is home. The unions that represent the workforce in these institutions also argue for their continuation. And federal funding still favors institutional care. Programs that help people live in the community require waivers from federal rules, and are capped so that their growth is restricted.

In the field of mental health, de-institutionalization is taking a somewhat different path. Drugs have made it possible for most people with severe mental illnesses to live independently so long as their medications are well-managed. When they do require hospitalization, their stays are usually brief. Some people with mental illnesses must be confined for longer periods because they are a danger to themselves or others. But even those who represent a threat to public safety are sometimes able to live in secure settings in the community. People with developmental disabilities who have committed serious offenses but have been judged not competent to stand trial, for instance, are now often housed in their own rental homes, with 24-hour supervision by paid staff.

Where DSHS clients live while receiving long-term care

People who lived in more than one setting during a year are counted in each.

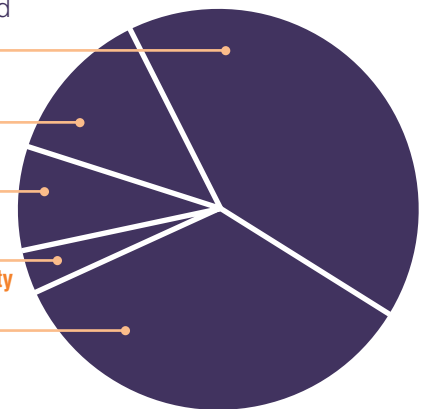
Their own or family home
27,070 (44%)

Adult Family Home
4,965 (8%)

Assisted Living Facility
4,350 (7%)

Adult Residential Care Facility
2,015 (3%)

Nursing Home
23,575 (38%)



Source: DSHS Client Services Data Base for FY2000, RDA



Photo courtesy DSHS Aging and Adult Services

The cost of care in institutions is generally higher than the cost of care in the community. This is not always true, however. People who need around-the-clock staff and/or intensive medical services may cost as much or more to serve in their own homes as in an institution.

To keep down costs, some states are experimenting with “cluster housing” in which people with various kinds of disabilities live in their own apartments in the same housing complex, so that caregiving staff can be shared and costs contained. However, some advocates vehemently oppose this because they see it as the “ghetto-ization” of people with disabilities. They insist that their freedom of choice should not be subordinated to budget considerations.

Given these changes in law, attitudes and expectations, the human services system must confront these issues:

How committed are we to freedom of choice and self-directed care for people with disabilities? We like to think that we are, as a society, respectful of everyone’s right to live as they please. We like to think that a disability is not a sentence to lifelong poverty and dependence. But our government budgets are very limited. Are we willing to pay for the array of choices that most people with disabilities want - and, at the same time, to support the institutional care that others still need or prefer?

Are we ready to welcome people with disabilities in our neighborhoods? In many neighborhoods, there is powerful opposition to any group home or shared living arrangement that involves people who are mentally ill, developmentally disabled, or in recovery from chemical dependency. Yet the point of community-based living arrangements is to recognize the contributions that people with disabilities can make, and to include them in the life of the community. How can we overcome the resistance and prejudice that prevent genuine integration and acceptance for people with disabilities?

Balancing individual and family privacy and the need to protect children and adults from harm

It is not easy to balance everyone's right to freedom to be left alone, and everyone's responsibility to protect others from harm. And we don't always get it right. When should a neighbor call the DSHS toll-free number, 1-866-ENDHARM, to report suspected child neglect? When should a social worker intervene in the life of a struggling family? And most traumatic of all, when should the state remove a child from his or her home?

These are questions that neighbors, the news media, lawmakers, experts, and social workers struggle with every day.

These gut-wrenching choices are not limited to decisions about children. When should an adult with dementia be declared incompetent to make his or her own decisions? At what level of functioning should a person with a developmental disability be empowered to hire and fire his or her own caregiver? When people have no family members to help make these decisions, what are the responsibilities of state and local government human service agencies?

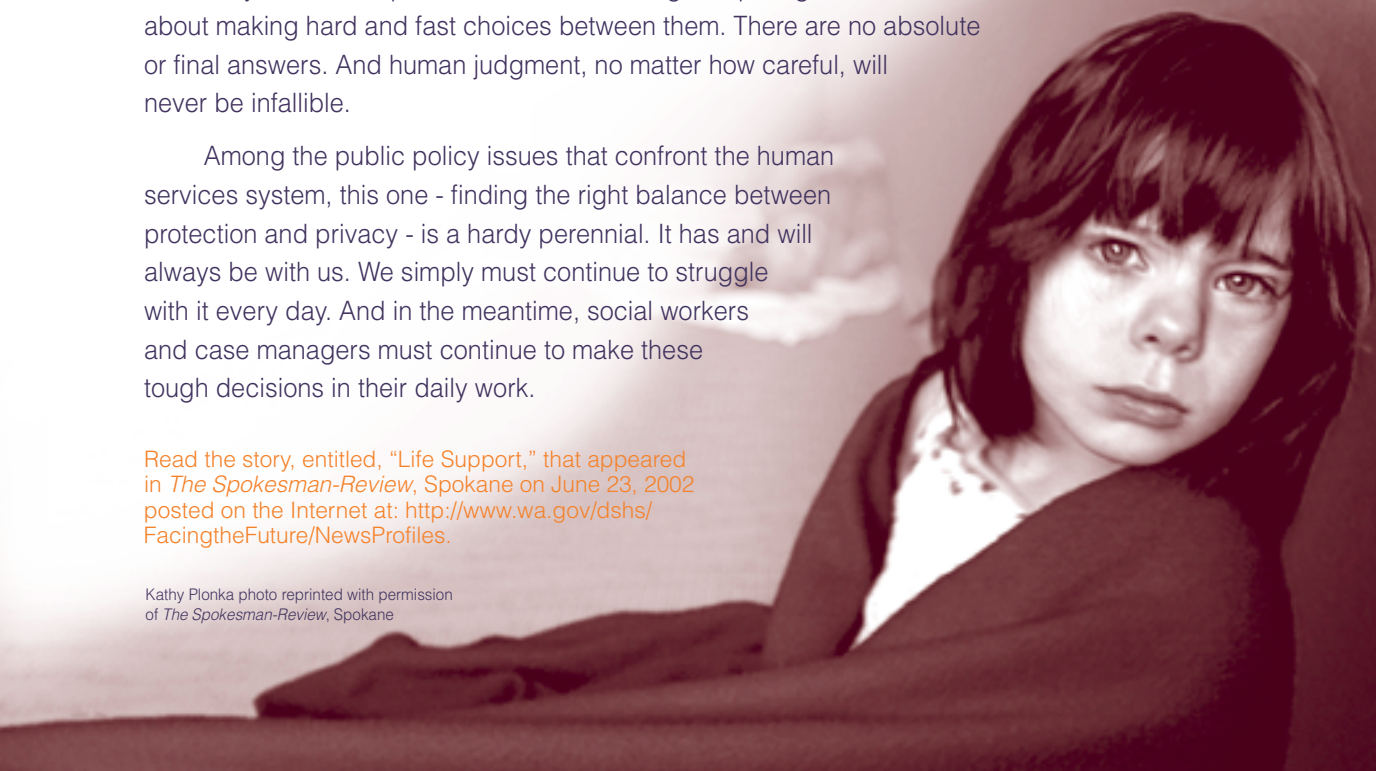
How can we, as a society, best ensure that our government protects those who need protection, while allowing the maximum possible freedom and privacy to our fellow citizens?

Truly, these are questions about balancing competing values; not about making hard and fast choices between them. There are no absolute or final answers. And human judgment, no matter how careful, will never be infallible.

Among the public policy issues that confront the human services system, this one - finding the right balance between protection and privacy - is a hardy perennial. It has and will always be with us. We simply must continue to struggle with it every day. And in the meantime, social workers and case managers must continue to make these tough decisions in their daily work.

Read the story, entitled, "Life Support," that appeared in *The Spokesman-Review*, Spokane on June 23, 2002 posted on the Internet at: <http://www.wa.gov/dshs/FacingtheFuture/NewsProfiles>.

Kathy Plonka photo reprinted with permission of *The Spokesman-Review*, Spokane



Balancing consumer choice and consumer protection, reducing litigation

There is a growing movement for greater consumer choice in human services. People want to choose how and where they receive services, and from whom.

DSHS supports that desire for choice, and is working to give more people more choices. In fact, Washington's Aging and Adult Services is a national leader in providing people with more choices and more services provided in their homes rather than in nursing homes. But the greater the degree of choice, the greater the need for vigilance on the part of family members, neighbors, friends, and even strangers.



Photo courtesy DSHS Aging and Adult Services

Some very vulnerable people want to be able choose to pay relatives or hire their own assistants to care for them. They ought to have that choice. Government should not tell people how to live simply because they have a disability. But that puts DSHS in a difficult situation, because DSHS is often held responsible when people choose caregivers that fail to do the right thing.

This problem is exacerbated by a Washington law that requires the state to pay 100 percent of the compensatory damages even if it is as little as one percent responsible for negligence or abuse by a caregiver.

Washington is one of only six states in the country with no form of sovereign immunity, which means citizens can sue the state for ordinary torts. Because one of five Washington residents is a client of DSHS, Washington taxpayers have great exposure to lawsuits.

Today, we must find new ways to accommodate people's need for safety and their right to autonomy and self-directed care, while clearly defining what the state's responsibility is, and where that responsibility ends.

We also need to face the fact that government alone cannot fully protect people from harm. We can only succeed when everyone is involved in looking out for their relatives, friends and neighbors, and promptly reporting suspected abuse or neglect.

Even more significant to Washington taxpayers is the use of lawsuits in federal court against the state, filed by advocacy groups seeking more services for their various constituencies. Recent examples include a claim for more services for children in foster care and claims for more and better services for the mentally ill and developmentally disabled. These lawsuits expose the taxpayers to tens of millions, or even hundreds of millions, of dollars of obligations without regard for available revenue or other state priorities.

Balancing community safety and constitutional rights

Only three percent of the approximately 1,000 sex offenders released from prison each year are committed to the Special Commitment Center (SCC), a mental health facility run by DSHS. To be committed to the SCC, an offender who has completed his sentence must be “more likely than not” to reoffend and must have a mental abnormality that can be treated by mental health professionals.

Offenders who are likely to reoffend but have completed their sentences, and do not have a mental abnormality are released from prison back into the community.

In spite of the large numbers of sex offenders who are released from prison directly to the community, most media and public attention has focused on the three percent who go through the SCC, and who, at the insistence of the court, must have some prospect for eventual release to less restrictive living arrangements.

No one wants a facility to house these offenders in their community. But if communities have to have them (and state law says six counties do) local citizens want absolute assurance that offenders will be carefully and closely monitored to protect the community.

Characteristics of a Special Commitment Center Resident

There is no stereotypical profiles that adequately describes all residents of the Special Commitment Center (SCC). The one characteristic residents share is a history of violent sexually motivated offenses.

Some SCC residents have serious or chronic physical, mental, or developmental disabilities. Some residents have attended college and have held well-paying jobs. Some are poorly educated and have limited work skills or experiences. A significant number grew up in dysfunctional families and were victims of abuse. Many residents have spent long periods of their lives in prison or in other institutions.

SCC residents may be classified into two groups – those who participate in treatment and those who do not. Their treatment is designed in response to their individual needs. It is reasonable to assume that only individuals who actively participate and succeed in treatment are eligible for community transition.

Successful treatment participants have made a conscious decision to change. The key factor for defining success in treatment is the resident’s ability to demonstrate change in every day life – change that is consistent over time, not just during treatment sessions and groups.

Background information on Special Commitment Center programs is posted on the DSHS Internet site at <http://www.wa.gov/dshs/geninfo/sccoverview.html>

There are several problems with this. The first is that offenders have constitutional rights, and these rights include the right to hope for eventual freedom if they improve in treatment, follow the rules, and refrain from further illegal acts. Eventually, some offenders will be released back into the community from the less restrictive community facilities. Communities will have to come to terms with this fact.

Another problem is money. Because communities insist on very high levels of supervision for people coming out of the SCC, the cost of the less restrictive living facilities may be very high. Today, keeping an offender in prison costs about \$25,000 a year; keeping an offender in the SCC costs about \$100,000 a year. Some of the models for less restrictive living arrangements would cost \$400,000 per year per offender.

Ultimately, we will have to acknowledge that no amount of spending will make us 100 percent safe from sex crimes, and we will have to balance our need for safety with other priorities for public spending.



Photo by Della Jordan

Planning for an aging population

In the 1960s, when baby boomers swelled the ranks of the young, pundits wrote about the “youth culture” they created. A decade from now, when boomers begin to retire in large numbers, pundits may very well write about the “elder culture” that this demographic bulge creates.

The demographic trend of aging boomers comes at a time when Americans are living longer than ever before, and this means that aging boomers will be with us for a very long time. This is sure to strain public budgets for health care. If current trends continue, boomers’ lives will be extended by more medical innovations and more expensive drugs than any previous generation.

Aging boomers will also need long-term care. We are currently building a long-term care system based on peoples’ preference for home care - and on the availability of low-wage workers who provide home care. This precarious system may fall apart when there are more people who need care than there are workers willing to provide it cheaply.

Failing to anticipate and address these problems may result in system collapse, or at the very least, the draining of resources from services to the young to services for the old.

Recruiting and Keeping Skilled Human Services Workers • There is another problem created by the demographics of aging, and that is the recruitment and retention of staff for DSHS and for all its partners in the human services field. Between 2002 and 2007, 24 percent of DSHS staff will be eligible to retire.

In the past, human services agencies benefited from corporate hiring practices that discriminated against women and minorities, because government agencies, although lower paying, would hire from these populations, and would allow women to take time off for families. Today, with more private sector opportunities for these groups, attracting and keeping bright, capable people to the human services field is more challenging. We can hope that a recent upsurge in interest in public service will be sustained over time; we can also work to ensure that public service in general, and human services in particular, are widely understood to be uniquely satisfying and rewarding vocations.



Integrating services

Success is rarely simple.



Photo and news story reprinted with permission of The Tri-City Herald

Barbara Fernald has her sights set on a job as regional director for human resources of a major hotel chain, which would take her from the Tri-Cities to Southern California. Not bad for a single mother of two who spent 15 years dependent on welfare assistance much of the time. Then she got help from WorkFirst, Washington's welfare reform program for financially struggling families. It helped with career training, day care, tuition assistance, clothing and bus tickets. In three years she rose from seasonal banquet server at the Red Lion Inn in Richland to its human resources director.

Read the complete story in *The Tri-City Herald* posted on the Internet on Facing the Future Profiles, located at: <http://www.wa.gov/dshs/FacingtheFuture/NewsProfiles>

Thirty years ago, when DSHS was first created, a part of its promise was that people would be able to find and use multiple services easily, without a lot of red tape or trips from one office to another. This promise has not yet been kept.

In fact, in some respects the system has moved away from integration rather than toward it. Services that used to be housed in Community Services Offices have moved away into separate facilities. This atomization was driven, at least in part, by the feeling that no one wanted to set foot in a "welfare office," and that clients of other services - vocational rehabilitation or senior services, for instance - would be more comfortable coming to a separate building.

Integration of services has also been impeded by the increasing specialization of the human services field. As we have learned more about the specific, unique needs of different client groups - for instance, people with developmental disabilities - we have developed services that are better tailored to meet their specific needs. This specialization is good news for people who get more customized services. But the more specialized human services become, the more distance there is between the professions and academic disciplines that deal with different problems, different groups of people, and different stages of life.

The need for better integration of services is becoming more urgent because there are more and more people who use multiple services. People with multiple problems are often most at risk of harm when their care is not carefully coordinated; they are also often the most expensive clients when their lives spin out of control. Better coordination of care means better preventive measures that keep tragedies from happening, and costs from escalating.

In the past, the problem of integrating services has often been seen as an organizational problem - a problem of bureaucratic turf issues and competition for scarce dollars. But organizational issues are only one part of the problem. Federal and state funding sources create silos that keep programs separate. Medicaid and Medicare, for instance, often serve the same people, but have completely separate funding sources, structures, functions and rules. Blended funding that combines the resources of more than one program (or, as it is sometimes called, "braided funding") requires overcoming obstacles such as federal rules, accounting procedures, and state budget restrictions.

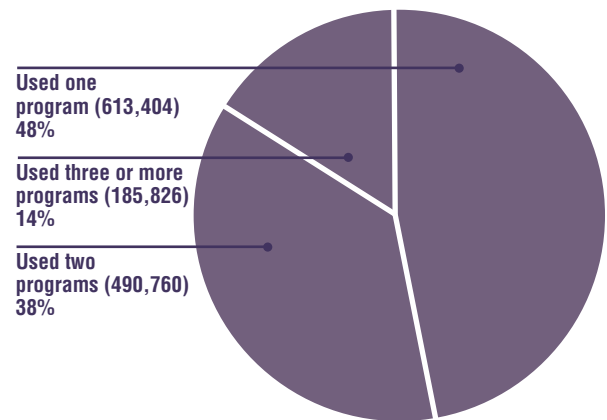
Cultural differences between various academic disciplines and specialties in human services are also part of the problem. People who work in the field of developmental disabilities, for instance, seek to protect their constituents from the prejudice and misunderstanding of those outside their field.

Also, mental health professionals often find themselves working at cross purposes with their colleagues in drug and alcohol treatment. When someone is both mentally ill and addicted, there is often conflict about which ought to come first - mental health treatment or chemical dependency treatment. Each discipline recognizes the shortcomings of this approach and is working toward truly integrating mental health and chemical dependency treatment.

Advocates also play a role in the atomization of human services. Advocate groups lobby for public sympathy and government funding for particular programs and particular groups of people. To them, victory is defined as building the budget and the capacity of the program that serves their favored constituency - not in creating flexible funding or organizational structures that promote integrated services.

In spite of these obstacles, there has been progress in integrating services for individual clients. Today, when an individual or a family is affected by multiple issues such as alcohol abuse, child neglect, poverty, and mental illness, professionals from all the involved programs meet to talk about how to coordinate all the needed services. This new approach, called "No Wrong Door," is showing real promise in putting together the coordinated care that these families need. Cross-training is provided for all the professionals involved, so that each has a better understanding of what others can provide. Information about the client is shared via a single, multi-agency confidentiality agreement. Eventually, this model will be expanded across the state.

Number of DSHS clients using more than one program in FY 2000



Source: DSHS Client Services Data Base, Research and Data Analysis



In spite of its success, however, the “No Wrong Door” project is not the whole answer. It deals with integration one client at a time. It builds capacity for further integration by educating staff about their colleagues in other divisions and disciplines. But it does not address the larger organizational and budget issues that impede broader, deeper integration across all human services systems and levels of government.

Finding our way out of this dilemma requires rethinking the business model of how human services are delivered. Co-location of services, perhaps into neighborhood or community centers, could reunite the services that have, over the years, fled from the stigma of the “welfare office.” Since welfare has been replaced by WorkFirst, that stigma is - or ought to be - a thing of the past.

Ultimately, the goal of integrated services will only be achieved when all the impediments to it are addressed at once: the inflexibility of funding sources; the complexity that arises when federal, state and local governments are layered on top of one another; the cultural rivalries and misunderstandings between academic disciplines and programs; and the single-issue advocacy that keeps attention focused on individual programs rather than the functionality of the whole system.

This problem is not unique to DSHS. In the private sector, people who need both mental health and chemical dependency treatment often face the same difficulty in coordinating two forms of treatment. So do those who seek to blend medical and non-medical home care services for people with disabilities and the elderly.

Nor is service integration unique to the field of human services. The U.S. military perpetually struggles with rivalry between its branches. Federal, state and local law enforcement agencies struggle to coordinate across services and jurisdictions. High-tech companies struggle to make their products and services compatible with one another. In nearly every field of human endeavor, getting all the moving parts synchronized is part of the challenge.

This is one of many areas in which human beings are unlikely to achieve perfection. But it is also an area in which more diligent effort can yield significant, sustained progress and improvement.

Rethinking the division of labor between federal, state and local governments

Over many years, we have created a complex and sometimes dysfunctional system for sharing the cost of human services between federal, state and local governments. Currently, governments at every level look for ways to shift costs to some other level of government in order to balance their own budgets.

There may once have been some logical basis for the division of labor between all of these government entities. But today, the logic has been lost, and all that is left is complexity, confusion, and the constant search to find ways to shift costs.

For instance, because Medicare does not include a prescription drug benefit, thousands of Medicare beneficiaries turn to Medicaid to pay for their pharmaceuticals. Medicare is fully funded by a federal government insurance program, but Medicaid costs are split between federal and state governments. Thus, if Congress were to pass a bill that provided drug benefits under Medicare, it would significantly reduce the cost of Medicaid and save the state of Washington (and other states as well) a great deal of money.

Funding for mental health services is another example of complexity and cost-shifting. Counties collect a small amount of property tax for the specific purpose of funding mental health programs and programs for people with developmental disabilities. These funds are not nearly enough to provide for all the needs of people with developmental disabilities or mental illnesses, however. The bulk of those services are paid for by the state and federal government using mostly Medicaid funding. Counties therefore have an incentive to encourage clients to make more use of state and federally financed programs - and those programs have an incentive to encourage clients to use county-paid programs and services.

Greater efficiency, clarity, and quality could be achieved if there were a systematic effort to rethink the division of labor between the various levels of government.